Division of Alcohol and Substance Abuse

and

Medical Assistance Administration

Chemical-Using Pregnant (CUP) Women Program

Billing Instructions

WAC 388-533-0300

November 2002

About this publication

This publication supersedes all previous MAA Chemical-Using Pregnant (CUP) Women Program Billing Instructions.

Published by the Medical Assistance Administration
Washington State Department of Social and Health Services
November 2002

What's new in this publication?

MAA last published this document in 1993. Most of the material in this new publication adds current program practice that was omitted in the 1993 publication. The new publication now includes the process for extended stays, billing instructions, and information on Medicare and Healthy Options. Other things in the new publication worth noting are that MAA has discontinued Revenue Code 169 for extended stays, has added resource linkages, and has defined basic program services.

Additional Resource Material

The information contained in this billing instruction serves as a guide to develop CUP Women program policies and procedures in the provider facility's program manuals, per WAC 388-533-0300. Additional resource material can be found in:

- DASA's "*Pregnant Women Chemical Dependency/Abuse Information Resource Guide*;"
- MAA' s "*ABC's Of First Steps Manual*"; and
- The Department of Health's (DOH) "*Guidelines for Screening for Substance Abuse During Pregnancy*."

You can obtain information on the Maternal Substance Abuse Screening Initiative and Guidelines at the "*Did You Ask*?" web site at: www.didyouask.org.

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Important Contacts

A provider may use MAA's toll-free lines for questions regarding its programs; however, MAA's response is based solely on the information provided to the [MAA] representative at the time of the call or inquiry, and in no way exempts a provider from following the rules and regulations that govern MAA's programs. [WAC 388-502-0020(2)].

Who do I contact about payments, denials, general questions regarding claims processing, or Healthy Options?

Provider Relations Unit
1-800-562-6188

Who do I contact if I'm interested in becoming a CUP Women program provider or have questions regarding CUP Women program policy?

Sue Green, Division of Alcohol and Substance Abuse (DASA)
1-360-438-8087

Todd Slettvet, MAA
1-360-725-1626

Where do I send my claims?

Hard Copy Claims:
Division of Program Support
PO Box 9247
Olympia WA 98507-9247

How do I obtain copies of billing instructions or numbered memoranda?

Go to MAA's web site at:
http://maa.dshs.wa.gov Click on "Provider Publications/Fee Schedules"

Who do I contact if I want to request an extended stay?

Todd Slettvet, MAA CUP Women Program Manager
Division of Program Support
Family Services Section
PO Box 45530
Olympia, WA 98504-5530
sletttd@dshs.wa.gov
1-360-725-1626

Who do I contact if I have questions regarding…

Private insurance or third party liability, other than Healthy Options?

Coordination of Benefits Section
1-800-562-6136

Electronic Billing?

Electronic Media Claims Help Desk
1-360-725-1267

Internet Billing?
http://maa.dshs.wa.gov/ecs.htm

Definitions

This section defines terms and acronyms used throughout these billing instructions.

Alcohol & Drug Addiction Treatment & Support Act (ADATSA) - A state program which funds medical and treatment services for persons who are incapable of gainful employment due to alcohol or other drug addiction.

Alcohol and Substance Abuse, Division of (DASA) - The division within the Department of Social and Health Services that has lead responsibility for addressing services for chemically addicted persons, including pregnant women. DASA certifies and monitors alcohol and drug treatment facilities in the state.

Chemical-Using Pregnant (CUP) Women Program – The CUP Women program is a Medicaid-funded, hospital-based, intensive detoxification and medical stabilization program for alcohol or drug using/ dependent) pregnant women and their exposed fetuses.

Client - An applicant for, or recipient of, a DSHS medical care program.

Community Services Office(s) (CSO) - An office of the department that administers social and health services at the community level. [WAC 388-500-0005]

Core Provider Agreement - The basic contract that MAA holds with providers serving MAA clients. The provider agreement outlines and defines terms of participation in Medical Assistance Administration programs.

Department - The state Department of Social and Health Services [DSHS]. [WAC 388-500-0005]

Detoxification - Care and treatment in a residential or hospital setting of persons intoxicated or incapacitated by alcohol or other drugs during the period in which the person is recovering from the transitory effects of intoxification or withdrawal. Acute detoxification provides medical care and physician supervision; subacute detoxification is non-medical.

Explanation of Benefits (EOB) - A coded message on the Medical Assistance Remittance and Status Report that gives detailed information about the claim associated with that report.

Explanation of Medicare Benefits (EOMB) - A federal report generated for Medicare providers displaying transaction information regarding Medicare claims processing and payments.

Hospital-Based Medical Stabilization - Medical hospital inpatient care to medically manage the acute detoxification and medical stabilization of a pregnant woman and her fetus.

Intensive Inpatient Treatment- Nonhospital, DASA-certified facilities for sub-acute/detoxified patients focused on primary chemical dependency services in residential or outpatient settings.

Managed Care - A prepaid comprehensive system of medical and health care delivery including preventive, primary, specialty, and ancillary health services. [WAC 388-538-050]

Maximum Allowable - The maximum dollar amount that a provider may be reimbursed by MAA for specific services, supplies, or equipment.

Medicaid - The state and federally-funded aid program that covers the Categorically Needy (CNP) and Medically Needy (MNP) programs.

Medical Assistance Administration (MAA) - The administrations within DSHS authorized by the secretary to administer the acute care portion of the Title XIX Medicaid, Title XXI Children's Health Insurance Program (CHIP), and the state-funded medical care programs, with the exception of certain non-medical services for persons with chronic disabilities.

Medically Necessary - A term for describing [a] requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent the worsening of conditions in the client that endanger life, or cause suffering or pain, or result in an illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction. There is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the client requesting the service. For the purpose of this section, "course of treatment" may include mere observation or, where appropriate, no treatment at all. [WAC 388-500-005]

Medical Identification card - Medical Identification cards are the forms DSHS uses to identify clients of medical programs. These cards are good only for the dates printed on them. Clients will receive a Medical Identification card in the mail each month they are eligible. These cards are also known as DSHS Medical ID cards or medical coupons and were formerly called MAID cards.

Patient Identification Code (PIC) - An alphanumeric code that is assigned to each MAA client consisting of:

- First and middle initials (a dash (-) must be entered if the middle initial is not indicated).
- Six-digit birthdate, consisting of numerals only (MMDDYY).
- First five letters of the last name (and spaces if the name is fewer than five letters).
- Alpha or numeric character (tiebreaker).

Provider or Provider of Service - An institution, agency, or person:

- Who has a signed agreement [Core Provider] with the department to furnish medical care, goods, and/or services to clients; and
- Is eligible to receive payment from the department. [WAC 388-500-0005]

Program Support, Division of (DPS) – The division within MAA responsible for providing administrative services for the following:

- Claims Processing;
- Disease Management;
- Family Planning Services;
- First Steps;
- Field Services;
- Managed Care Contracts and PCCM; and
- Provider Relations.

Rehabilitation Services - Hospital-based intensive inpatient substance abuse treatment, medical care, and assessment and linkages.

Remittance and Status Report (RA) - A report produced by MAA's claims processing system (know as the Medicaid Management Information System or MMIS) that provides detailed information concerning submitted claims and other financial transactions.

Third Party - Any entity that is or may be liable to pay all or part of the medical cost of care of a medical program client. [WAC 388-500-0005]

Usual and Customary Fee - The rate that may be billed to the department for a certain service or equipment. This rate *may not exceed:*

- The usual and customary charge that you bill the general public for the same services; or
- If the general public is not served, the rate normally offered to other contractors for the same services.

Washington Administrative Code (WAC) - Codified rules of the state of Washington.

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About the Program

What is the purpose of the CUP Women program?

The intent of the CUP Women program is to:

- Reduce harm to a mother and her fetus who need medical stabilization for obstetric and perinatal complications often present in chemically-dependent pregnant women; and

- Provide all of the following services in one setting to improve the health of the woman and the fetus:

  - ✓ Immediate access to care;
  - ✓ Medical detoxification/stabilization; and
  - ✓ Chemical dependency treatment

The CUP Women program is designed to change the behavior of pregnant women and improve birth outcomes. Chemical-using pregnant women are high-risk for medical complications and often resistant to change. However, during pregnancy, they are more likely to accept treatment and successfully change their behavior. Substance abuse remains one of the most overlooked obstetric complicating factors during prenatal care. Prenatal substance abuse screening, treatment, and medical care should be initiated as early as possible during pregnancy.

How is the CUP Women program different from other chemical dependency programs?

The CUP Women program is the only program that offers all of the following services in a hospital setting:

- Acute, medical detoxification;
- Stabilization;
- Medical; and
- Chemical dependency treatment.

Note: The CUP Women program is reimbursed by MAA, not by DASA or any other county-based program.

This acute level of care does not exist in other intensive inpatient treatment facilities. Due to the potential for serious health risks when detoxifying a chemical-using pregnant woman and fetus, acute medical services must be present. Once the client is medically stabilized, chemical dependency treatment begins.

The CUP Women program is an entry point into a larger care continuum. When a pregnant woman is ready to enter treatment, the ability to place her quickly into a safe environment is critical. A number of intervention and referral sources exist in community, medical, and treatment agencies. Often, several providers are linked in motivating the same pregnant woman to access care. Other substance abuse treatment programs exist for pregnant women that can be served in a non-hospital based setting. These intensive inpatient treatment models such as social detoxification, outpatient services, or residential facilities, often link with prenatal care providers, but are not equipped to meet the acute medical needs associated with these high-risk pregnancies. The CUP Women program is a unique partnership between many multidisciplinary providers. The program provides immediate access to care by removing the barriers of a prerequisite ADATSA referral, Medicaid eligibility, or limited referral source existing in other programs.

How are hospitals reimbursed for CUP Women services?

Hospitals are reimbursed through the ratio of costs to charges (RCC) method by MAA. Ancillary (e.g., lab, pharmacy, etc.) charges related to the CUP Women stay may be billed on the same claim with the CUP Women services. Charges for delivery, premature labor, or any another acute medical inpatient stay must be billed on a separate claim form. There is no separate funding or approval required from DASA chemical dependency programs for CUP Women program reimbursement.

Where are CUP Women services provided?

CUP Women services are provided at acute care hospital-based inpatient facilities approved by the Medical Assistance Administration (MAA) and the Division of Alcohol and Substance Abuse (DASA). MAA does not cover CUP Women services provided out-of-state.

Who may refer to the CUP Women program?

Referrals to the CUP Women program may include, but are not limited to:

- The client or family member;
- A local substance abuse outreach program;
- A First Steps Provider;
- A First Steps Social Worker;
- The Children's Services Division;
- A Medical provider; or
- DASA-certified agencies.

The CUP Women hospital facility coordinates with all agencies that provide services to a referred client.

Client Eligibility

Who is eligible to receive CUP Women services?

Adult and adolescent women are eligible for CUP Women services if they are:

- Pregnant;
- Have a medical need (including observation or monitoring);
- Have a substance abuse history and are screened "at risk";
- Have a current DSHS Medical Identification (ID) card (or have a pending application for one) with one of the program identifiers in the table below:

☞ **Note:** If a CUP woman is not currently a Medicaid client, initiate a Medicaid application within five days of admission. If a client has not had an ADATSA or chemical dependency assessment, contact the ADATSA Assessment Center DASA 24-Hour Help Line at 1-800-562-1240 (or the local number of the Center, if known) within the initial five-day period. If a client is not eligible for the CUP Women program, refer them to the local chemical dependency center, or call the 24-hour DASA Help Line for local resources at 1-800-562-1240.

Medical Identification Card Program Identifier	Medical Program
CNP	Categorically Needy Program
CNP **CHIP**	Categorically Needy Program - Children's Health Insurance Program
CNP **QMB**	Categorically Needy Program - Qualified Medical Beneficiary
LCP **MNP**	Limited Casualty Program – Medically Needy Program

☞ **Note:** If a client is not pregnant at admission, she is not eligible for CUP Women services. Clients with Medical ID cards with the three- or five-day DETOX ONLY section completed are NOT eligible for CUP Women services. Three- to five-day detoxification is funded at the county level and contains no medical component.

Are clients enrolled in a Healthy Options managed care plan eligible for CUP Women services?

Yes, but outside of their Healthy Options plan through MAA's fee-for-service system. If the client delivers during the 26-day stay, or during an approved extension, then delivery and newborn care must be billed fee-for-service. Coverage and billing guidelines found in these billing instructions apply to managed care clients. Bill MAA directly.

Clients who are enrolled in managed care will have an "HMO" identifier in the HMO column on their DSHS Medical ID cards.

Coverage

What is covered?

The CUP Women Program can admit a patient for up to 26 days of care. Often, medical episodes, long-term substance abuse, resistance to treatment, or other factors slow treatment progression. An approval for extended days may be requested (see page C.4). The CUP Women program covers:

- Acute and sub-acute detoxification and stabilization of the pregnant woman and her fetus; and

- Rehabilitation, primary treatment education, assessment for ongoing chemical dependency treatment, and discharge planning.

CUP Women services include the following:

- **Acute Detoxification/Medical Stabilization/Rehabilitation Services**

  - ✓ **Primary Acute Detoxification/Medical Stabilization** - approximately 3-5 days.

  - ✓ **Secondary Sub-Acute Detoxification/Medical Stabilization** - approximately 7-10 days.

  - ✓ **Rehabilitation/Treatment** - remainder of stay may include the following:

    - Assessment for ongoing treatment/clean and sober housing;
    - Referrals and linkage to all providers and case managers;
    - Chemical dependency education;
    - Ongoing medical attention including obstetrical appointments;
    - Ultrasounds or medical services;
    - Methadone maintenance when appropriate;
    - Reintegration/reentry into the community;
    - Ongoing treatment if need assessed;
    - Referrals as appropriate;
    - Partial hospitalization/day treatment; and
    - Outpatient services.

✓ **Other Services** - In addition to the core services of detoxification, medical stabilization, and rehabilitation, other services may include, but are not limited to:

- Medical nutrition therapy;
- Childbirth preparation & delivery;
- Art and movement therapy;
- Drug education and awareness for family;
- Self-reliance education;
- Parenting education in the care of alcohol/drug-affected infants;
- Family dynamics education;
- Vocational counseling;
- Psychological counseling;
- Psychotherapy and group therapy;
- Life skills, including use of Medicaid transportation and First Steps childcare;
- Financial management;
- Household management;
- Physical appearance consultation; and
- Day Treatment - Outpatient Treatment.

☞ **Note:** In the event that needed services are not available on site, refer clients to applicable community services. In these situations, the client remains an inpatient and is not discharged and then re-admitted to the CUP Women program. Often a case manager or attendant escorts the client off-site or the service visit occurs at the hospital.

- **Transportation Services**

CUP Women services include the use of Medicaid-funded transportation to and from medical services while the woman is an inpatient at the CUP Women facility.

Clients sometimes travel to see an established provider and require an attendant away from the hospital. MAA's Transportation Services program has contracted brokers who provide this service. MAA covers the transportation of the client and an attendant.

For further information regarding MAA's Transportation Services program:

Access the Transportation Services website at:
http://maa.dshs.wa.gov/transportation/index.html

or call:
1-800-562-3022

- **Interpreter Services**

  CUP Women services include the use of interpreter services.

  MAA covers: Interpreter services for the client during a medical appointment.

  DASA covers: Interpreter services requested by a chemical dependency provider/ADATSA center.

For further information regarding MAA's Interpreter Services program access the Interpreter Services website at:
http://maa.dshs.wa.gov/interpreterservices

What if the pregnancy ends before the client completes the CUP Women program?

If the pregnancy ends before completing the CUP Women program, regardless of the reason, providers may continue a client's treatment if recommended by the treatment planner. If a less restrictive alternative treatment option is more appropriate, refer the client to the best setting. Whenever appropriate, make every effort to keep the mother and child together.

Length of Treatment – Request for Extended Stay

The maximum length of treatment, without approval for extended stay, is 26 days. There is no minimum length of stay. If an extended stay is needed, a request must be made to MAA (see *Important Contacts*). MAA may approve additional days, when justified. If a client leaves the program or is discharged and then returns, it is considered a new CUP Women admittance and stay.

Determine if the length of treatment may need to be extended by examining the:

- Needs of the individual;
- Progress made;
- Medical status; and
- Individualized treatment plan.

When requesting additional days, include the following in your verbal or written request to the MAA CUP Women Program Manager (see *Important Contacts* section):

- Client's patient identification code (PIC);
- Date of admit;
- Number of additional days needed;
- Hospital's name and address; and
- Justification of need for additional days.

After an extended stay request is received, the MAA CUP Women Program Manager will review the request and send a written decision to the provider.

Provider Requirements

Program Administration

An approved facility must:

- Adopt policies and procedures that include a philosophical working statement describing the purpose and techniques of treatment for chemical-using/abusing pregnant women;

- Make available guidelines and resources for current medical treatment methods by specific drug and or alcohol type;

- Establish linkages with state and community providers to ensure a working knowledge exists of current medical and substance abuse resources; and

- Ensure that a current chemical dependency assessment has been completed for all CUP Women program clients using the latest criteria of the American Society of Addiction Medicine (ASAM) which considers the following when determining the level of care:

  - ✓ Pregnancy, post-pregnancy, and parenting status;
  - ✓ Number of children, custody status, residence, and visitation schedule;
  - ✓ History of Child Protective Service intervention;
  - ✓ History of death or loss of children;
  - ✓ Childcare needs;
  - ✓ Family Planning practices and needs;
  - ✓ Suicidal/homicidal ideation;
  - ✓ Domestic violence history;
  - ✓ Sexual assault history;
  - ✓ Ongoing mental health needs;
  - ✓ Current and past history of chemical use during pregnancy;
  - ✓ Previous pregnancy prenatal care;
  - ✓ Relationship addiction;
  - ✓ Family dynamics;
  - ✓ Family reunification plans;
  - ✓ Living situation/housing;
  - ✓ Legal issues; and
  - ✓ Eating disorders.

Who is approved to provide CUP Women services?

Providers are approved for reimbursement by the Medical Assistance Administration (MAA) for providing CUP Women services to MAA clients when the provider:

- Meets certification standards for the provided levels of treatment and medical care as prescribed in:

  - ✓ WAC 388-805-015;
  - ✓ Division of Alcohol & Substance Abuse (DASA) policies; and
  - ✓ MAA policies.

- Meets hospital standards as prescribed by the Joint Commission on Accreditation of Healthcare Organization (JCACHO).

- Is not licensed as an Institution for Mental Disease (IMD) under Centers for Medicare and Medicaid (CMS) criteria.

Report any change in certification, level of care, or program operation to the MAA CUP Women Program Manager (see *Important Contacts* section). Prior to providing CUP Women services, you must submit your program application to, and receive approval from, DASA and MAA.

Notifying Clients of Their Rights (Advance Directives)

(42 CFR, Subpart I)

All Medicare-Medicaid certified hospitals, nursing facilities, home health agencies, personal care service agencies, hospices, and managed health care organizations are federally mandated to give **all adult clients** written information about their rights, under state law, to make their own health care decisions.

Clients have the right to:

- Accept or refuse medical treatment;
- Make decisions concerning their own medical care; and
- Formulate an advance directive, such as a living will or durable power of attorney, for their health care.

Billing

How do I bill for CUP Women services?

Use the UB-92 claim form to bill the hospital-based, intensive CUP Women services provided to the client. Follow these guidelines when billing:

1. In order to facilitate processing of claims under this program, MAA has established a daily room and board revenue code. This revenue code is 129. Use this revenue code for the entire CUP stay. You must indicate this revenue code in form locator 51 of the UB-92. MAA reimburses for daily room rate charges with this revenue code only.

> ☞ **Note:** For stays that exceed 26 days, bill:
>
> - Hardcopy by attaching a copy of the MAA written approval for extended stay with the claim;
> - Electronically by entering the date of approval and dates of service approved in the ***Remarks*** Field.

2. All claims for CUP Women services **must** have a primary diagnosis code related to pregnancy and a secondary diagnosis code related to alcohol or drug abuse. When billing MAA for CUP Women services, you must use the appropriate diagnosis codes from the following list of ICD-9-CM diagnosis codes:

   a) Primary diagnosis

      i. 648.33 (drug dependency – antepartum);
      ii. 648.34 (drug dependency – postpartum);
      iii. 648.43 (for alcohol dependency – antepartum); or
      iv. 648.44 (for alcohol dependency – postpartum).

   b) Secondary diagnosis

      i. 304 through 304.93 (drug dependency); or
      ii. 303 through 303.93 (alcohol dependency).

3. For all other (ancillary) revenue codes, refer to MAA's Inpatient Hospital Billing Instructions.

4. When billing:

   a) Direct Entry - Request an ***S*** batch (inpatient non-DRG) when calling the Claims Control Unit at (360) 725-1950 for batch activation.
   b) Electronically - CUP Women services must be entered as follows:

      RECORD TYPE: 10
      RECORD NAME: Provider Data
      FIELD NUMBER: 2

      Indicate the type of batch equivalent to an ***S*** batch (inpatient non-DRG).

5. When inpatient hospital acute detoxification and medical stabilization services are 24 hours or less, you must bill these services as a short stay on an outpatient claim.

   Inpatient hospitals must use their regular provider number and follow MAA's Inpatient Hospital Billing Instructions to bill non-DRG claims. *Do not* use the provider number issued for three-day or five-day detoxification programs, as these are different programs and funded through the county.

   MAA reimburses the hospital a percentage of ***allowed charges*** for these services. CUP Women services are exempt from DRG reimbursement methodology. Reimbursement is based on the hospital's ratio of cost-to-charges (RCC) rate and usual and customary fee.

How do I bill for physician/ARNP services?

Physicians, physician's assistants-certified (PACs), and advanced registered nurse practitioners (ARNPs) may provide inpatient hospital medical services to the client receiving CUP Women services. To bill MAA, use the Current Procedural Technology (CPT™) code from MAA's Physician-Related Services (RBRVS) Billing Instructions that most closely describes the service actually provided **(CPT codes 99221 through 99238, and/or 99431 and 99433)**.

Use the HCFA-1500 claim form when billing for physician/ARNP services.

Physicians and ARNPs may provide continuation of medical services to pregnant clients on an outpatient basis separate from the CUP Women Program. To bill MAA in this instance, use the CPT code from MAA's Physician-Related Services (RBRVS) Billing Instructions **(CPT codes 99201 through 99215)**, that most closely describes the service provided.

☞ **Note:** You **must** use both the primary and secondary ICD-9-CM diagnosis codes listed in **#2a and #2b on page E.1** when billing MAA for physician/ARNP services.

What is the time limit for billing? **[Refer to WAC 388-502-0150]**

MAA requires providers to submit an initial claim, be assigned an internal control number (ICN), and adjust all claims in a timely manner. MAA has two timeliness standards: 1) for initial claims; and 2) for resubmitted claims.

- **Initial Claims**

  ✓ MAA requires providers to obtain an ICN for an **initial claim** within 365 days from any of the following:

  - The date the provider furnishes the service to the eligible client;
  - The date a final fair hearing decision is entered that impacts the particular claim;
  - The date a court orders MAA to cover the services; or

- ✓ The date DSHS certifies a client eligible under delayed[1] certification criteria. MAA may grant exceptions to the 365 day time limit for initial claims when billing delays are caused by either of the following:
  - ➢ DSHS certification of a client for a retroactive[2] period; or
  - ➢ The provider proves to MAA' s satisfaction that there are other extenuating circumstances.

- **Resubmitted Claims**

  Providers may **resubmit, modify**, **or adjust** any timely initial claim, except prescription drug claims, for a period of 36 months from the date of service. Prescription drug claims must be resubmitted, modified, or adjusted within 15 months from the date of service.

  ☞ **Note:** MAA does not accept any claim for resubmission, modification, or adjustment after the designated time period listed above.

- The designated time periods do not apply to overpayments that the provider must refund to DSHS. After the designated time periods, a provider may not refund overpayments to MAA by claim adjustment. The provider must refund overpayments to MAA by a negotiable financial instrument, such as a bank check.

- The provider, or any agent of the provider, must not bill a client or a client's estate when:
  - ✓ The provider fails to meet these listed requirements; and
  - ✓ MAA does not pay the claim. **(See WAC 388-502-0160 for more information.)**

What fee should I bill MAA for eligible clients?

Bill MAA your usual and customary fee.

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[1] **Delayed Certification** - According to WAC 388-500-0005, delayed certification means department approval of a person's eligibility for a covered service made after the established application processing time limits. If, due to delayed certification, the client becomes eligible for a covered service that has already been provided, **the provider must not bill**, demand, collect, or accept payment from the client or anyone on the client's behalf and then bill MAA for the service; and **must promptly refund** the total payment received from the client or anyone acting on the client's behalf and then bill MAA for the service.

Eligibility Established After Date of Service but Within the Same Month -If the client becomes eligible for a covered service that has already been provided because the client applied to the department for medical services later in the same month the service was provided (and is made eligible from the first day of the month), **the provider must not** bill, demand, collect, or accept payment from the client or anyone acting on the client's behalf for the service; and **must promptly refund** the total payment received from the client or anyone acting on the client's behalf and then bill MAA for the service.

[2] **Retroactive Certification** -According to WAC 388-500-0005, retroactive period means the three calendar months before the month of application (month in which client applied). If, due to retroactive certification, the client becomes eligible for a covered service that has already been provided, **the provider must not bill**, demand, collect, or accept payment from the client or anyone acting on the client's behalf for any unpaid charges for the service; **and may refund** any payment already received from the client or anyone acting on the client's behalf, and after refunding the payment, the provider may bill MAA for the service.

How do I bill for clients who are eligible for both Medicare and Medicaid?

If a client is eligible for both Medicare and Medical Assistance (otherwise know as "dually-eligible"), **you must <u>first</u> submit a claim to Medicare and accept assignment within Medicare's time limitations.** MAA may make an additional payment after Medicare reimburses you.

- If Medicare pays the claim, the provider must bill MAA within six months of the date Medicare processes the claim.
- If Medicare denies payment of the claim, MAA requires the provider to meet MAA's initial 365-day requirement for initial claim (see page E.3).
- Codes billed to MAA must match codes billed to Medicare when billed as a Medicare Part B crossover claim.

Medicare Part A

Medicare Part A is a health insurance program for:

- Individuals who are 65 years of age and older;
- Certain individuals with disabilities (under 65 years of age); or
- Individuals with End-Stage Renal Disease (permanent kidney failure requiring dialysis or transplant).

Medicare Part A helps individuals pay for hospital stays, skilled nursing facilities, hospice and some home health care. Check the client's red, white and blue Medicare card for the words "Part A (hospital insurance)" in the lower left corner of the card to determine if they have Medicare Part A coverage. Under Part A, Medicare will pay its allowed charges, minus any deductible and/or coinsurance, when appropriate.

Effective April 1, 1999, payments for services rendered to Qualified Medicare Beneficiaries (QMBs) is limited to the Medicare payment if the Medicare payment exceeds the amount MAA would pay for the same service (whether normally DRG or RCC reimbursed) had the service been reimbursed under the ratio of costs-to-charges (RCC) payment method.

When billing Medicare:

- Indicate *Medical Assistance* and include the patient identification code (PIC) on the claim form as shown on the Medical Identification card. Enter the Medical Assistance provider number.
- Accept assignment.
- If Medicare has allowed the service, in most cases Medicare will forward the claim to MAA. MAA then processes your claim for any supplemental payments.
- If Medicare does not forward your claim to MAA **within 30 days** from its statement date, send the UB-92 claim form and a copy of the Part A Explanation of Medical Benefits (EOMB) to MAA for processing.
- When Part A services are totally disallowed by Medicare but are covered by MAA, bill MAA on the UB-92 claim form and attach copies of Medicare's EOMB with the denial reasons.

☞ **Note:**

- ✓ Medicare/Medical Assistance billing claims must be received by MAA within six (6) months of Medicare's EOMB paid date.
- ✓ A Medicare Remittance Notice or EOMB must be attached to each claim.

QMB (Qualified Medicare Beneficiaries) Program Limitations:

QMB with CNP (Qualified Medicare Beneficiaries with Categorically Needy Program)

(Clients who have CNP identifiers on their Medical Identification card in addition to QMB)

- If Medicare **and** Medicaid cover the service, MAA will pay only the deductible and/or coinsurance up to Medicare or Medicaid's allowed amount, whichever is less.

- If only Medicare **and not Medicaid** covers the service, MAA will pay only the deductible and/or coinsurance up to Medicare's allowed amount.

- If Medicaid covers the service and Medicare does not cover the service, MAA will reimburse for the service.

Medicare Part B

Benefits covered under Part B include: **Physician, outpatient hospital services, home health, durable medical equipment, and other medical services and supplies** not covered under Part A.

When the words *"This information is being sent to either a private insurer or Medicaid fiscal agent,"* appear on your Medicare remittance notice, it means that your claim has been forwarded to MAA or a private insurer for deductible and/or coinsurance processing.

If you have received a payment or denial from Medicare, but it does not appear on your MAA Remittance and Status Report (RA) within 45 days from Medicare's statement date, you should bill MAA directly.

- If Medicare has made payment, and there is a balance due from MAA, you must submit a HCFA-1500 claim form (with the "XO" indicator in field 19). Bill only those lines Medicare paid. Do not submit paid lines with denied lines. This could cause a delay in payment or a denial.

- If Medicare denies services, but MAA covers them, you must bill on a HCFA-1500 claim form (without the "XO" indicator in field 19). Bill only those lines Medicare denied. Do not submit denied lines with paid lines. This could cause a delay in payment or a denial.

- If Medicare denies a service that requires prior authorization by MAA, MAA will waive the prior authorization requirement but will still require authorization. Authorization or denial of your request will be based upon medical necessity.

Payment Methodology – Part B

- MMIS compares MAA's allowed amount to Medicare's allowed amount and selects the lesser of the two. (If there is no MAA allowed amount, we use Medicare's allowed amount.)

- Medicare's payment is deducted from the amount selected above.

- If there is *no* balance due, the claim is denied because Medicare's payment exceeds MAA's allowable.

- If there *is* a balance due, payment is made towards the deductible and/or coinsurance up to MAA's maximum allowable.

MAA cannot make direct payments to clients to cover the deductible and/or coinsurance amount of Part B Medicare. MAA *can* pay these costs to the provider on behalf of the client when:

1) The provider accepts assignment; and

2) The total combined reimbursement to the provider from Medicare and Medicaid does not exceed Medicare or Medicaid's allowed amount, whichever is less.

☞ **Note:**

- ✓ Medicare/Medical Assistance billing claims must be received by MAA within six (6) months of the Medicare EOMB paid date.
- ✓ A Medicare Remittance Notice or EOMB must be attached to each claim.

Third-Party Liability

The Medical Assistance Administration (MAA) is required by federal regulation to determine the liability of third-party resources that are available to MAA clients. All resources available to the client that are applicable to the costs of medical care must be used. Once the applicable resources are applied, MAA may make payment on the balance if the third-party payment is less than the allowed amount.

To be eligible for MAA programs, clients must assign their insurance rights to the state in conformance with federal requirements.

It is the provider's responsibility to bill MAA appropriately after pursuing any potentially liable third-party resource when:

- Health insurance is indicated on the Medical ID card; or
- There is a possible casualty claim; or
- You believe insurance is available.

> If you would like assistance in identifying an insurance carrier, call the Third-Party Resource Program at 1-800-562-6136, or refer to the TPL Carrier Code List on MAA's web site at http://maa.dshs.wa.gov.

What records must be kept? (Refer to WAC 388-502-0020)

Enrolled providers must:

- Keep legible, accurate, and complete charts and records to justify the services provided to each client, including, but not limited to:

  - ✓ Patient's name and date of birth;
  - ✓ Dates of service(s);
  - ✓ Name and title of person performing the service, if other than the billing practitioner;
  - ✓ Chief complaint or reason for each visit;
  - ✓ Pertinent medical history;
  - ✓ Pertinent findings on examination;
  - ✓ Medications, equipment, and/or supplies prescribed or provided;
  - ✓ Description of treatment (when applicable);
  - ✓ Recommendations for additional treatments, procedures, or consultations;
  - ✓ X-rays, tests, and results;
  - ✓ Plan of treatment and/or care, and outcome; and
  - ✓ Specific claims and payments received for services.

- Assure charts are authenticated by the person who gave the order, provided the care, or performed the observation, examination, assessment, treatment or other service to which the entry pertains.

- Make charts and records available to DSHS, its contractors, and the US Department of Health and Human Services, upon their request, for at least six years from the date of service or more if required by federal or state law or regulation.

A provider may contact MAA with questions regarding its programs. However, MAA's response is based solely on the information provided to MAA's representative at the time of inquiry, and in no way exempts a provider from following the laws and rules that govern MAA's programs.
(Refer to WAC 388-502-0020[2])

How to Complete the UB-92 Claim Form

Only form locators that pertain to billing MAA are addressed below.

When submitting more than one page of the UB-92, be sure to fully complete the first page. Only the *detail lines* are picked up from the second page. Please clearly indicate Page 1 of 2, Page 2 of 2, etc., in the *Remarks* section (*form locator 84*).

If a client is not eligible for the entire hospital stay, bill only dates of service for which the client is eligible.

When billing electronically, indicate claim type "S" for RCC.

☞ **Note:** Shaded fields are required fields only for UB-92 Medicare/Medicaid Crossover Claims." **Medicare/Medicaid Crossover Claims cannot be billed electronically.**

FORM LOCATOR NAME AND INSTRUCTIONS FOR COMPLETION:

1. **Provider Name, Address & Telephone Number** - Enter the provider name, address, and telephone number as filed with the MAA Division of Program Support (DPS).

3. **Patient Control No.** - This is a 20-digit alphanumeric entry **that you may use as your internal reference number**. You create this number. Once you have submitted this account number to MAA, it will appear on the Remittance and Status Report under the column titled *Patient Account Number*.

4. **Type of Bill** - Indicate type of bill using 3 digits as follows:

Type of Facility (first digit)
1 = Hospital
Bill Classification (second digit)
1 = Inpatient

Frequency (third digit)
1 = Admit through discharge claim
2 = Interim - First Claim
3 = Interim - Continuing Claim
4 = Interim - Last Claim
5 = Late Charge(s) Only Claim

6. **Statement Covers Period** - Enter the beginning and ending dates of service for the period covered by this bill.

12. **Patient Name** - Enter the client's last name, first name, and middle initial as shown on the client's Medical Identification card.

13. **Patient's Address** - Enter the client's address.

14. **Patient's Birthdate** - Enter the client's birthdate.

15. **Patient's Sex** - Enter the client's sex.

17. **Admission Date** - Enter the date of admission (MMDDYY).

18. **Admission Hour** - The hour during which the patient was admitted for inpatient care. Use the appropriate two-digit code listed in the next column.

Code	Time: A.M.	Code	Time: P.M.
00	12:00 - 12:59 (Midnight)	12	12:00 - 12:59 (Noon)
01	01:00 - 01:59	13	01:00 - 01:59
02	02:00 - 02:59	14	02:00 - 02:59
03	03:00 - 03:59	15	03:00 - 03:59
04	04:00 - 04:59	16	04:00 - 04:59
05	05:00 - 05:59	17	05:00 - 05:59
06	06:00 - 06:59	18	06:00 - 06:59
07	07:00 - 07:59	19	07:00 - 07:59
08	08:00 - 08:59	20	08:00 - 08:59
09	09:00 - 09:59	21	09:00 - 09:59
10	10:00 - 10:59	22	10:00 - 10:59
11	11:00 - 11:59	23	11:00 - 11:59

19. **Type of Admission** - Enter type of admission.

1 = Emergent
2 = Urgent
3 = Elective
4 = Newborn

20. **Source of Admission** - Enter source of admission.

1 = Physician Referral
2 = Clinic Referral
3 = HMO Referral
4 = Transfer from a hospital
5 = Transfer from a nursing facility
6 = Transfer from another health care facility
7 = Emergency Room
8 = Court/Law Enforcement
9 = Information Not Available

21. **Discharge Hour** - The hour during which the patient was discharged from care.

22. **Patient Status** - Enter one of the following codes to represent the disposition of the patient at discharge:

01 = Discharge to home or self care (routine discharge)
02 = Transferred to another short-term general hospital
03 = Discharged/transferred to nursing facility (SNF)
04 = Discharged/transferred to nursing facility (ICF)
05 = Transferred to an exempt unit or hospital
06 = Discharged/transferred to home under the care of an organized home health service organization
07 = Left against medical advice
08 = Discharged/transferred to home care of a Home IV provider
20 = Expired
30 = Still patient

Medicare Crossover claims only

39-41. Value Codes and Amounts - Enter one of the following, as appropriate:

45 = Accident Hour (use the chart listed next to form locator 18 for admission hours)

80 = Newborn's birth weight in gram

39A: **Deductible**: Enter the code *A1*, and the deductible as reported on your EOMB.

39D: **ENC Rate**: Enter Med's ENC rate as reported on the EOMB.

40A: **Coinsurance**: Enter the code *A2*, and the coinsurance as reported on your EOMB.

40D: **Encounter Units**: Enter the encounter units Medicare paid, as reported on EOMB.

41A: **Medicare Payment**: Enter the payment by Medicare as reported on your EOMB.

41D: **Medicare's Process Date**: Enter the date that Medicare processed the claim, as reported on your EOMB in numerals only (*MMDDYY*).

42. **Revenue Code** - Enter revenue code 129 for Room and Board Charges. For any other (ancillary) revenue codes, refer to MAA's Inpatient Billing Instructions.

43. **Revenue or Procedure Description** - Enter a narrative description of the related revenue included on this bill. Abbreviations may be used. Enter the description *total charges* on line 23 of this form locator on the final page.

44. **HCPCS/Rates** - Enter the accommodation rate for inpatient bills.

46. **Units of Service** - Enter the quantity of services listed by revenue or procedure code(s).

47. **Total Charges** - Enter charges pertaining to the related revenue code(s) or procedure code(s). Enter the total of this column as the last detail on line 23 of this form locator on the last page.

48. **Noncovered** - Any noncovered charges pertaining to detail revenue or procedure codes should be entered here. (These services will be *categorically denied*.) Enter the total of this column as the last detail on line 23 of this form locator on the last page.

50. **Payer Identification: A/B/C** - Enter if all health insurance benefits are available.

50A: Enter *Medicaid*.
50B: Enter the name of additional insurance (e.g., Medicare, Aetna, etc.), if applicable.
50C: Enter the name of additional insurance, if applicable.

51. **Provider Number** - Enter the hospital provider number issued to you by DPS. This is the seven-digit provider number beginning with a *3* that appears on your Remittance and Status Report.

Medicare Crossover claims only

51A: Enter the seven-digit Medicaid provider number that appears on your Remittance and Status Report.

51B: Enter your Medicare provider number.

54. **Prior Payments: A/B/C** - Enter the amount due or received from all insurances. **Do not include Spenddown or EMER here. See form locator 57.**

54A: Enter any prior payments from payor listed in form locator 50A.
54B: Enter any prior payments from payor listed in form locator 50B.
54C: Enter any prior payments from payor listed in form locator 50C.

55. **Estimated Amount Due: A/B/C** –

55A: Enter the estimated amount due from MAA minus any amounts listed in form locators 48, 54, and 57.
55B: Not required to be filled in.
55C: Not required to be filled in.

57. **Due from Patient (Patient Liability)** Enter the total patient liability amount which includes Spenddown and/or EMER.

☞ Refer to the bottom of the client's *Approval for MI EMER/Spenddown Met* Letter issued by the local DSHS Community Service Office for the Spenddown/EMER amount.

58. **Insured's Name: A/B/C** - If other insurance benefits are available and coverage is under another name, enter the insured's name.

60. **Cert-SSN-HIC-ID NO.** - Enter the Medicaid Patient (client) Identification Code (PIC) -an alphanumeric code assigned to each Medical Assistance client - exactly as shown on the Medical Identification card. This information is obtained from the client's current monthly Medical Identification card and consists of the client's:

a. First and middle initials (or a dash [-] *must* be used if the middle initial is not available).
b. Six-digit birthdate, consisting of *numerals only* (MMDDYY).
c. First five letters of the last name. If there are fewer than five letters in the last name, leave spaces for the remainder before adding the tie breaker.
d. An alpha or numeric character (tie breaker).

61. **Insurance Group Name** - If other insurance benefits are available, enter the name of the group or the plan through which insurance is provided to the insured.

62. **Insurance Group Number** - If other insurance benefits are available, enter any identification number that identifies the group through which the individual is covered.

63. **Treatment Authorization** - Enter the assigned authorization number (be sure to enter all nine digits).

65. **Employer Name** - If other insurance benefits are available, enter the name of the employer that *might provide* or *does provide* health care coverage insurance for the individual.

67. **Principal Diagnosis Code** - Enter:

- 648.33 (drug dependency – antepartum);
- 648.34 (drug dependency – postpartum);
- 648.43 (for alcohol dependency – antepartum); or
- 648.44 (for alcohol dependency – postpartum).

68-75. **Other Diagnosis Codes** - Enter one of the following ICD-9-CM diagnosis codes:

- 304 - 304.93 (drug dependency); or
- 303 - 303.93 (alcohol dependency).

76. **Admitting Diagnosis -** Enter:

- 648.33 (drug dependency – antepartum);
- 648.34 (drug dependency – postpartum);
- 648.43 (for alcohol dependency – antepartum); or
- 648.44 (for alcohol dependency – postpartum).

80. **Principal Procedure Code** - The code that identifies the principal procedure performed during the period covered by this bill.

81 A-E **Other Procedure Codes** - The codes identifying all significant procedure(s) other than the principal procedure.

82. **Attending Physician I.D.** - Enter the seven-digit provider identification number of the attending physician. Do not complete this box with a clinic billing number. For attending physicians not enrolled in the Medical Assistance program, enter the name of the attending physician in this form locator.

83. **Other Physician I.D.** - Enter the referring provider number, or if unknown, enter the name of the provider who referred the client to services. If the client is under PCCM, you must use the referring PCCM provider number.

84. **Remarks** - Enter any information applicable to this stay that is not already indicated on the claim form such as extended stay approval.

Hospital Chemical Dependency
1111 Main St.
Anytown, WA 98000

3 PATIENT CONTROL NO: UB123456 | 4 TYPE OF BILL: 111

6 FED TAX NO | 5 STATEMENT COVERS PERIOD: FROM 10/01/02 THROUGH 10/20/02 | 7 DOW D | 8 N.C.D. | 9 C.C.D. | 10 L.R.D. | 11

2 PATIENT NAME: Mary Jane Smith

13 PATIENT ADDRESS: 1111 Market St. Anytown, WA 98000

14 BIRTHDATE	15 SEX	16 MS	ADMISSION 17 DATE	18 HR	19 TYPE	20 SRC	21 D HR	22 STAT	23 MEDICAL RECORD NO.	24	CONDITION CODES 25	26	27	28	29	30	31
MM/DD/YYYY	F		10/01/02	09	2	2	10	01									

32 CODE	OCCURRENCE DATE	33 CODE	OCCURRENCE DATE	34 CODE	OCCURRENCE DATE	35 CODE	OCCURRENCE SPAN FROM	THROUGH	36 A B C

	39 CODE	VALUE CODES AMOUNT		41 CODE	VALUE CODES AMOUNT
a					
b					
c					
d					

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
129	Daily Room, CUP	800.00		19	15200.00		
250	Pharmacy			10	300.00		
300	Laboratory			5	200.00		
001	Total Charges				15700.00		

SAMPLE

50 PAYER	51 PROVIDER NO	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56
Medicaid	3XXXXXX				15700.00	

57 — DUE FROM PATIENT

58 INSURED'S NAME	59 P REL	60 CERT. - SSN - HIC - ID NO.	61 GROUP NAME	62 INSURANCE GROUP NO.
Mary Jane Smith		MJ 999999 Smith A		

63 TREATMENT AUTHORIZATION CODES	64 ESC	65 EMPLOYER NAME	66 EMPLOYER LOCATION

67 PRIN. DIAG. CD.	68 CODE	69 CODE	OTHER DIAG. CODES		76 ADM. DIAG. CD.	77 E-CODE	78
.648.43	303.9				648.33		

79 P.C.	80 PRINCIPAL PROCEDURE CODE	DATE	81 OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE

82 ATTENDING PHYS. ID: 9999999 Dr. John Johnson

83 OTHER PHYS. ID

OTHER PHYS. ID

84 REMARKS

85 PROVIDER REPRESENTATIVE: X — 86 DATE

UB-92 HCFA-1450 — OCR/Original — -F.6-

I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

Hospital Chemical Dependency
1111 Main St.
Anytown, WA 98500

3 PATIENT CONTROL NO: UB123456
4 TYPE OF BILL: 111

6 STATEMENT COVERS PERIOD: 10/01/02 10/20/02

12 PATIENT NAME: Mary Jane Smith

13 PATIENT ADDRESS: 1111 Market St. Anytown, WA 98000

14 BIRTHDATE	15 SEX	16 MS	17 ADMISSION DATE	18 HR	19 TYPE	20 SRC	21 D HR	22 STAT	23 MEDICAL RECORD NO	CONDITION CODES
MM/DD/YYYY	F		10/01/02	09	2	2	10	01		

32 CODE	32 OCCURRENCE DATE	33 CODE	33 OCCURRENCE DATE	34 CODE	34 OCCURRENCE SPAN FROM	THROUGH	35
							A B C

	39 CODE	39 VALUE CODES AMOUNT		41 CODE	41 VALUE CODES AMOUNT
a	A1	812.00			7500.00
b					
c					
d					

09/01/02

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
129	CUP, Dailey Room	800.00		19	15200.00		
250	Pharmacy			10	300.00		
300	Laboratory			5	200.00		
					15700.00		

SAMPLE CROSSOVER

50 PAYER	51 PROVIDER NO.	52 REL. INFO.	53 ASG. BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56
Medicaid Medicare	3XXXXXX 5XXXXX			7500.00	812.00	

57 DUE FROM PATIENT ▶

58 INSURED'S NAME	59 P.REL	60 CERT. SSN HIC ID NO.	61 GROUP NAME	62 INSURANCE GROUP NO.
Mary Jane Smith Mary Jane Smith		999-99-9999 MJ 999999 Smith A		

63 TREATMENT AUTHORIZATION CODES	64 DCN	65 EMPLOYER NAME	66 EMPLOYER LOCATION

67 PRIN. DIAG. CO	68	OTHER DIAG. CODES 69	70	71	72	73	74	75	76 ADM. DIAG. CD.	77 E CODE	78
648.43	303.9								648.33		

79 P.C.	80 PRINCIPAL PROCED. (I/C) CODE	DATE	81 OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE
	OTHER PROCEDURE CODE	DATE			OTHER PROCEDURE CODE	DATE

82 ATTENDING PHYS. ID: 9999999 Dr. John Johnson

83 OTHER PHYS. ID

OTHER PHYS. ID

84 REMARKS

85 PROVIDER REPRESENTATIVE: X

86 DATE

UB-92 HCFA-1450 OCR/Original

CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

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